BEFORE THE PERSONNEL APPEALS BOARD

STATE OF WASHINGTON

JAMES GONZALES JR., Appellant, v. DEPARTMENT OF SOCIAL AND HEALTH SERVICES, Respondent.	Case No. DISM-01-0086 FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER OF THE BOARD

I. INTRODUCTION

1.1 **Hearing.** Pursuant to RCW 41.64.060 and WAC 358-01-040, this appeal came on for hearing before the Personnel Appeals Board, GERALD L. MORGEN, Vice Chair. The hearing was held at Western State Hospital, Hearings Conference Room, 9601 Steilacoom Boulevard, Lakewood, Washington, on March 25, 26, and 27 2003, and May 13 and 14, 2003. BUSSE NUTLEY, Member, listened to the recorded proceedings, reviewed the file and exhibits and participated in the decision in this matter.

1.2 **Appearances.** Appellant James Gonzales Jr. was present and was represented by Michael Davis, Attorney at Law. Kara Larsen, Assistant Attorney General, represented Respondent Department of Social and Health Services.

1.3 **Nature of Appeal.** This is an appeal from a disciplinary sanction of immediate suspension followed by dismissal for neglect of duty, malfeasance, gross misconduct and willful violation of

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agency policies. Respondent alleges that between November 1999 and July 2000 Appellant engaged in repeated physical and psychological abuse of a patient.

1.4 **Citations Discussed**. WAC 358-30-170; Baker v. Dep't of Corrections, PAB No. D82-084 (1983); McCurdy v. Dep't of Social & Health Services, PAB No. D86-119 (1987); Parramore v Dep't of Social & Health Services, PAB No. D94-135 (1995); Rainwater v. School for the Deaf, PAB No. D89-004 (1989); Harper v. WSU, PAB No. RULE-00-0040 (2002); Skaalheim v. Dep't of Social & Health Services, PAB No. D93-053 (1994); Holladay v. Dep't of Veterans Affairs, PAB No. D91-084 (1992).

II. FINDINGS OF FACT

2.1 Appellant James Gonzales Jr. was a permanent employee for Respondent Department of Social and Health Services. Appellant and Respondent are subject to Chapters 41.06 and 41.64 RCW and the rules promulgated thereunder, Titles 356 and 358 WAC. Appellant filed a timely appeal with the Personnel Appeals Board on October 16, 2001.

2.2 Appellant began his employment at Western State Hospital in May 1989. As a Mental Health Technician (MHT) 1, Appellant worked on Ward S6, providing day-to-day care for chronic medical/psychiatric patients with dementia/Alzheimer's. Appellant has no history of formal or informal corrective/disciplinary action, and his performance evaluations reflect that he worked well with patients on the wards and was well liked.

2.3 Clarence was a patient on Ward S6 (patients on Ward S6 were moved to Ward E5 sometime in spring 2000). Clarence was approximately 79 years old, and he was admitted to Western State Hospital on June 12, 1999 due to vascular dementia following a stroke. Clarence was wheelchair bound and required complete personal care. He was a small, frail man and weighed approximately

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110 to 120 pounds; his skin was described as "paper thin" and it was prone to tears and bruising. Because of his mental condition, Clarence was known to get agitated and at times staff found it difficult to provide care to him. Clarence also displayed repetitive behavior, such as repeatedly pounding or tapping on hard surfaces (for example, tables and walls). Sometimes Clarence would bite, kick and hit staff while being changed or bathed. Clarence was verbal and lucid the majority of the time; however, at times he displayed short-term memory loss.

2.4 Appellant was assigned to provide one-on-one care to Clarence during the evening shift. Appellant was the only male Mental Health Technician on the ward during that shift. Other male employees may have worked as "floats" on the ward during the shift.

2.5 Patricia Johnson, a Mental Health Technician 2, began working with Appellant in 1989, and they developed both a workplace and a social friendship. Both she and Appellant described themselves as "best friends."

2.6 In July 2000, appointing authority C. Jan Gregg, Chief Executive Officer, was informed of allegations that Appellant was subjecting Clarence to physical and psychological abuse. After several investigations, Ms. Gregg notified Appellant by letter dated October 3, 2001, of his immediate suspension, effective October 2 through October 17, 2001, followed by dismissal, effective October 18, 2001 from his position as a Mental Health Technician (MHT) 1. Ms. Gregg charged Appellant with neglect of duty, malfeasance, gross misconduct and willful violation of agency policy. Ms. Gregg alleged that Appellant engaged in repeated physical and psychological abuse of patient Clarence from November 1999 through July 2000.

2.7 Appellant denies that he engaged in any type of physical or psychological abuse against Clarence. During the hearing of this appeal, Ms. Johnson provided the majority of the testimony

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regarding the allegations contained in the October 3, 2001 disciplinary letter. Licensed Practical Nurse (LPN) Josephine Liteanu (formerly Josephine Knight) and LPN Victoria Murphy presented testimony that corroborated a number of the incidents described by Ms. Johnson.

2.8 In making a determination of credibility, we find that Ms. Johnson has presented consistent descriptions of the behavior in which Appellant engaged. Ms. Johnson did not report or document Appellant's behavior because she did not want to jeopardize his job, and because she believed she could get him to stop. Ms. Johnson credibly described how disturbed she felt to witness Appellant abuse Clarence. Ms. Johnson also felt guilty and powerless to protect Clarence despite asking Appellant to leave Clarence alone. Further, we find no motive for Ms. Johnson to lie about the events she described. Because Appellant and Ms. Johnson were close friends, it is more probable than not, that Appellant did not censor his more egregious behavior when Ms. Johnson was present because he trusted her not to tell.

2.9 During her testimony before us, Ms. Murphy denied that she witnessed Appellant engage in outright abusive behavior toward Clarence. Her testimony also contradicted statements that she gave during prior investigations into the allegation of patient abuse. Nonetheless, her testimony before us as well as her previous statements corroborate a number of the events described by Ms. Johnson and Ms. Liteanu, which we find constitute both physical and psychological abuse. Therefore, based on a preponderance of the credible evidence and testimony, we make the following findings.

2.10 Ms. Johnson described Appellant as a caring employee; however, shortly after Clarence was assigned to the ward, she noted a change in Appellant's behavior, specifically toward Clarence. Ms. Murphy also noted a negative change in Appellant's behavior in the fall of 1999.

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2.11 Ms. Johnson observed Appellant taunt and mimic Clarence. She also observed Appellant hit Clarence with wet washcloths. Appellant repeatedly pounded and/or tapped on tables, and he shot rubber bands at Clarence. Appellant hit Clarence with his fists, and he attempted to confuse Clarence by telling Clarence not to call him "James" and that his (Appellant's) name was "Vicente" (another employee of Western State Hospital).

2.12 Ms. Johnson observed Appellant engage in physically and psychologically abusive behavior toward Clarence on most days they worked together. Ms. Johnson repeatedly told Appellant to stop, but Appellant continued to engage in abusive behavior toward Clarence. On numerous occasions, Ms. Johnson would wheel Clarence to a different area to remove him from Appellant's presence.

2.13 On December 9, 1999, Appellant was assisting Clarence during the evening meal. Ms. Liteanu observed Appellant give a tray of food to Clarence. Although Clarence was able to feed himself, he often needed cueing. Rather than cue Clarence in a therapeutic manner, Appellant yelled at Clarence to "eat, eat, eat!" As Appellant was yelling "eat" he also began to repeatedly tap on the table, mimicking Clarence's tapping behavior. Ms. Liteanu yelled to Appellant "James!" and Clarence was moved away to remove him from the negative stimuli. Appellant followed them, however, and continued to mimic and taunt Clarence. Appellant's behavior agitated Clarence, who did not eat his dinner. Ms. Johnson was present in the dining room and witnessed the incident.

2.14 Ms. Liteanu subsequently reported to her supervisor, Linda Brown, RN 3, that Appellant was teasing Clarence. Ms. Brown spoke to several staff members and to Clarence regarding the allegation. However, she was unable to verify that the teasing had occurred. Ms. Brown did not interview Ms. Johnson. Ms. Brown also approached Appellant and informed him that someone

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made a claim that he was teasing Clarence. Appellant denied that he teased Clarence; however, Ms. Brown told him that any kind of teasing was not acceptable.

2.15 On another occasion, Ms. Liteanu was on the ward passing out medications. The door to Clarence's room was ajar, and Ms. Liteanu could see that Appellant was with Clarence. Ms. Liteanu observed Appellant throw a wet washcloth at Clarence, which hit the left side of Clarence's face. She described the manner in which Appellant threw the washcloth at Clarence as a "baseball throw." Clarence yelled and Ms. Liteanu entered the room. Appellant indicated to Ms. Litenau that Clarence was resistive, agitated and yelling. Ms. Liteanu observed that the side of Clarence's face was reddened.

2.16 Ms. Murphy also observed Appellant throw wet washcloths from the doorway of the room toward Clarence's bed. Although Ms. Murphy was uncertain as to whether Appellant was aiming at Clarence, she did observe the washcloths land on Clarence's bed and hit him along the legs/feet.

2.17 Registered Nurse 2 Carolyn Norris became aware that Clarence did not like male caregivers. Ms. Norris observed Clarence become agitated and yell, "Get him out of my room. I don't want him in my room" when Appellant checked in on him. She later gave a directive to staff that males not provide care to Clarence. Based on the conflict between Appellant and Clarence, Ms. Norris specifically told Appellant to "stay away" from Clarence.

2.18 Both Ms. Johnson and Ms. Murphy observed Appellant "sneak" into Clarence's room through the bathroom of an adjoining bedroom. Ms. Murphy noted that Clarence would become upset. Ms. Murphy observed Appellant tease and agitate Clarence and she would tell him to stop, and she also interceded on behalf of Clarence.

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2.19 On July 2, 2000, Clarence approached Ms. Johnson. Clarence was upset and crying, stating, "I thought this was America and stuff like this shouldn't happen." Clarence indicated he was going to use his wheelchair to block the entrance into his room, because he did not want anyone to enter his room. Ms. Johnson concluded that Clarence was upset because Appellant had snuck into Clarence's room.

2.20 Clarence returned to his room, however, and a short while later he approached Ms. Johnson again to ask if she was keeping an eye on his room. Clarence was still visibly upset and agitated. Ms. Johnson believed that Appellant was mistreating Clarence, and she became upset and decided it was time to document her conversation with Clarence in his progress record.

2.21 Clarence's daughter was visiting on July 2, 2000. She also approached Ms. Johnson about a complaint from her father that he had been hit. Ms. Johnson asked Clarence's daughter to make a report to Ms. Norris. Clarence's daughter spoke to Ms. Norris, and she told her of her father's complaint that he had been kicked in the kidneys. Ms. Norris made an entry into Clarence's progress record about her conversation with his daughter and the claim that Clarence was hit.

2.22 Later, Ms. Norris asked both Ms. Litenau and Ms. Johnson about Clarence's allegation of abuse. Both confirmed that they had witnessed Appellant abuse Clarence.

2.23 On July 11 or 12, 2000, Ms. Norris approached Clarence and asked him if staff had hurt him, and he indicated "yes." Ms. Norris told Clarence that he needed to tell her who it was. Clarence responded, "James."

2.24 Patricia Stuart, a Department of Health Investigator/Institutional Nurse Consultant, received an anonymous allegation of patient abuse occurring at Western State Hospital. Ms. Stuart is

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responsible for conducting investigations of complaints received from facilities licensed by the Department of Health, including Western State Hospital. On July 18, 2000, Ms. Stuart met with Ms. Gregg and informed her of the allegation of abuse and that she would conduct an investigation. After learning of the individuals involved, Ms. Gregg placed a number of staff on home assignment. In her letter to Appellant, dated July 18, 2000, Ms. Gregg informed Appellant that he was temporarily reassigned to his residence "due to an allegation of misconduct."

2.25 Ms. Stuart conducted interviews of 15 staff persons between July 18 and 19, 2000. Ms. Stuart also interviewed Clarence. Ms. Stuart provided credible testimony regarding her interview with Clarence. Ms. Stuart observed that Clarence "was quite alert" and although he displayed some short-term memory loss, he proved to be a "good reporter." Ms. Stuart noted that Clarence was "fairly somber" and when she asked how he liked being at Western State Hospital, he said, "I don't," and explained that people were "mean" to him. When Ms. Stuart asked if it was more than one individual, Clarence responded, "no, just one." He identified that person as "James" and described him as a Filipino. Appellant is Filipino. In Ms. Stuart's opinion, Clarence did not display confusion or delusions.

2.26 On July 19, 2000, the department referred the allegations of patient abuse to the Lakewood Police Department for a criminal investigation. Detective Sergeant Teresa Berg was assigned to conduct an investigation. On July 20, 2000, Detective Berg and Richard Cully, Security Manager at Western State Hospital, met with Clarence. When Ms. Berg asked about the allegations of abuse, Clarence was vague and he did not identify "James" as a person causing him harm.

2.27 Clarence's medical records did not contain entries of any unusual injuries or bruises. However, a preponderance of the evidence supports that, because patients on the ward bruised easily, staff was not conscientious about documenting injuries in patient charts.

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2.28 WSH has adopted Policy 3.3.4 that addresses patient abuse. The policy states:

> All patients have the right to treatment in an environment free of neglect, abuse and of abusive procedures. All employees are expected to diligently avoid both the substance and appearance of patient abuse while maintaining firm adherence to those principles of respect for the dignity of patients and their families. PATIENT RIGHTS ARE PARAMOUNT, AS SUCH, ALL EMPLOYEES ARE TO ASSURE THAT THOSE RIGHTS ARE HONORED TO THE FULL EXTENT OF THIS POLICY.

2.29 The policy defines physical patient abuse as "any physical contact...that involves the patient's body in a non-therapeutic way that is harmful or jeopardizes the safety and welfare of the patient." Physical patient abuse includes "squeezing, pinching, slapping, striking (with or without an object), pushing and using excessive force while restraining an agitated patient."

2.30 The policy defines psychological abuse as "any communication or interaction with a patient that is patently anti-therapeutic, dehumanizing, or that places the patient under excessive duress." Examples of psychological abuse include "inappropriate shouting at a patient, imitating or mocking the patient's behavior, or supporting the patient's delusional system."

2.31 DSHS Policy 6.04 requires employees "to perform duties and responsibilities in a manner that maintains standards of behavior and promotes public trust, faith, and confidence."

2.32 Appellant received the above policies on January 9, 1991.

2.33 C. Jan Gregg, Chief Executive Officer, was Appellant's appointing authority when the discipline was imposed. Prior to making a finding of misconduct, Ms. Gregg reviewed Detective Berg's investigation, the report by the Washington State Patrol, transcripts of the interviews

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conducted by an investigator with the Office of the Attorney General, and pictures taken in July 2000 of bruises on Clarence's arm and hand.

2.34 Ms. Gregg invited Appellant to meet with her to discuss the allegations. Appellant declined to meet in-person with Ms. Gregg on his attorney's advice because of a pending trial stemming from the allegations of patient abuse. However, Appellant's attorney submitted a written response to Ms. Gregg. The response indicated that Appellant could not address the allegations and requested that Ms. Gregg delay making a decision regarding Appellant's employment until after the trial.

2.35 Ms. Gregg decided to move forward with the disciplinary process, and she ultimately concluded that Appellant had subjected Clarence to physical and psychological abuse. In determining the level of discipline, Ms. Gregg considered a number of factors, including Appellant's 12 years of service, his employment record, his training and knowledge of the hospital's policy against patient abuse, his role as a care provider on the ward with extremely vulnerable patients, and his responsibility to provide therapeutic care to the patients.

2.36 Ms. Gregg concluded that Appellant's misconduct interfered with the hospital's responsibility to generate public trust and confidence by providing patients with the best possible care. She also reviewed Appellant's employment history, which reflected that he had routinely received positive performance evaluations and had received training on care of geriatric patients and on hospital policies, including the policy on preventing patient abuse.

2.37 Ms. Gregg stated that Appellant's primary responsibilities were to provide one-on-one care and to treat patients in a therapeutic and professional manner. She concluded that Appellant neglected to treat Clarence in a therapeutic manner. Ms. Gregg determined that Appellant engaged

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in gross misconduct when he subjected Clarence to physical abuse and treated him in a degrading manner by throwing wet washcloths at him. Ms. Gregg also concluded that Appellant did not treat Clarence with respect and dignity and instead created an atmosphere where Clarence was fearful to be on the ward.

2.38 Ms. Gregg concluded that Appellant violated Policy 6.04 (ethical conduct), Policy 3.4 (patient abuse), and policy 3.1.1 (regarding employee rights and responsibilities) by subjecting Clarence to both psychological and physical abuse and by failing to conduct himself within accepted standards of behavior.

2.39 Because Clarence was totally dependent on the caregivers on the ward, she found that Appellant's abuse was intolerable and that dismissal was the appropriate sanction.

III. ARGUMENTS OF THE PARTIES

3.1 Respondent argues that the credible evidence supports that Appellant subjected Clarence to both physical and psychological abuse. Respondent asserts that Appellant deliberately agitated Clarence by taunting and teasing him and attempted to confuse Clarence by telling him Appellant had a different name. Respondent argues that a preponderance of the credible testimony supports that Appellant shot rubber bands, threw wet washcloths and hit Clarence with his fists.

Respondent argues that Appellant treated Clarence in a manner not tolerated by the hospital and that employees are provided with specific training regarding policies that require them to treat patients with respect and dignity. Respondent argues that Appellant's acts constituted neglect of duty, willful violation of agency policy and gross misconduct. Respondent argues that the decision of the appointing authority to dismiss Appellant was appropriate.

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3.2 Appellant denies that he abused or mistreated Clarence in any way. Appellant argues Clarence was a patient who was extremely assaultive and when treated by others, would bite, kick, scratch, spit, and refuse his medications. Appellant argues that Clarence's behavior could have resulted in injuries to himself. Appellant argues that the type of hitting he is alleged to have engaged in would have left serious marks on Clarence; however, there was no evidence of the abuse and none of the medical records note any injuries to Clarence.

Appellant argues that the hospital was under extreme pressure to identify a scapegoat for its failure to develop and integrate a system of identifying and reporting abuse. Appellant claims that the United States Department of Health withdrew its funding of the hospital as a result of the hospital's violation of numerous regulations with regard to reporting patient abuse.

Appellant argues that he was never interviewed or questioned about the allegations and was denied the opportunity of due process to explain any interactions that he had with Clarence that may have appeared to others to be abuse. Appellant asserts that he is a 12-year employee, that he knew his job, was well trained, and had no history of progressive discipline. Appellant claims that he treated all patients with dignity, kindness and care. Appellant argues that the evidence fails to show that the abuse ever took place, and he asks to be reinstated and made whole and that he be granted attorney's fees.

IV. CONCLUSIONS OF LAW

4.1 The Personnel Appeals Board has jurisdiction over the parties and the subject matter.

4.2 In a hearing on appeal from a disciplinary action, Respondent has the burden of supporting the charges upon which the action was initiated by proving by a preponderance of the credible evidence that Appellant committed the offenses set forth in the disciplinary letter and that the sanction was appropriate under the facts and circumstances. WAC 358-30-170; Baker v. Dep't of Corrections, PAB No. D82-084 (1983).

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4.3 Neglect of duty is established when it is shown that an employee has a duty to his or her employer and that he or she failed to act in a manner consistent with that duty. McCurdy v. Dep't of Social & Health Services, PAB No. D86-119 (1987).

4.4 Gross misconduct is flagrant misbehavior that adversely affects the agency's ability to carry out its functions. Rainwater v. School for the Deaf, PAB No. D89-004 (1989). Flagrant misbehavior occurs when an employee evinces willful or wanton disregard of his/her employer's interest or standards of expected behavior. Harper v. WSU, PAB No. RULE-00-0040 (2002).

4.5 Willful violation of published employing agency or institution or Personnel Resources Board rules or regulations is established by facts showing the existence and publication of the rules or regulations, Appellant's knowledge of the rules or regulations, and failure to comply with the rules or regulations. Skaalheim v. Dep't of Social & Health Services, PAB No. D93-053 (1994).

4.6 In determining whether a sanction imposed is appropriate, consideration must be given to the facts and circumstances, including the seriousness and circumstances of the offenses. The penalty should not be disturbed unless it is too severe. The sanction imposed should be sufficient to prevent recurrence, to deter others from similar misconduct, and to maintain the integrity of the program. Holladay v. Dep't of Veterans Affairs, PAB No. D91-084 (1992).

4.7 Malfeasance is the commission of an unlawful act, the act of doing what one ought not to do, or the performance of an act that ought not to be done, that affects, interrupts, or interferes with the performance of official duty. Parramore v Dep't of Social & Health Services, PAB No. D94-135 (1995).

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4.8 We have found that the preponderance of credible evidence establishes that most likely Appellant physically and psychologically abused Clarence. Appellant's actions were deliberate, had a harmful effect on Clarence, and interfered with the agency's ability to provide a safe and therapeutic environment for the patients at Western State Hospital. There is no question that Appellant's acts constitute neglect of duty, gross misconduct, and willful violation of rules, and that dismissal is the appropriate sanction. Respondent, however, has failed to meet its burden of proving that Appellant's acts constituted malfeasance.

4.10 Appellant argues that he did not receive "due process" because he was not interviewed during the investigative process, and because the appointing authority terminated him from employment prior to a trial related to the abuse charges. The merit system rules do not require an appointing authority to postpone taking disciplinary action against an employee because criminal charges are pending. Ms. Gregg provided Appellant with an opportunity to meet with her and respond to the charges. Appellant, instead, elected to submit a written response to Ms. Gregg, which she considered in making her determination to dismiss him from employment at Western State Hospital. Therefore, Appellant received an opportunity to tell his side of the story. Furthermore, Appellant has failed to present any credible evidence to support his claim that Western State Hospital used him as a "scapegoat" because of the Department of Health's findings of deficiencies against the hospital.

4.9 Appellant requests attorney's fees. The Personnel Appeals Board is not a court and its authority is limited by chapter 41.64 RCW, the statute creating it. There is no express statutory

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provision for the Board to award attorney's fees. Cohn v. Dept. of Corrections, D91-009 (1992), aff'd Thurston County Super. Ct. No. 92-2-01245-3 (1993); Farnes v. Liquor Control Board, D82-32 (1982).

V. ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that the appeal of James Gonzales is denied.

DATED this _____ day of _____, 2003.

WASHINGTON STATE PERSONNEL APPEALS BOARD

_____
Gerald L. Morgen, Vice Chair

_____
Busse Nutley, Member

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